DOCUMENT RESUME

ED 271 654 CG 019 193

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TITLE Childhood Depression: Theories, Antecedents and Supportive Resources.
PUB DATE [84]
NOTE 19p.
PUB TYPE Information Analyses (070)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS Affection; *Affective Measures; Attribution Theory; Childhood Needs; Children; Communication Problems; *Depression (Psychology); Hospitalized Children; Psychiatric Hospitals; Resentment; *Social Support Groups; *Test Validity
IDENTIFIERS *Childhood Depression

ABSTRACT

Early detection and measurement of the intensity of childhood depression are important concerns for those treating depressed children. To examine issues of childhood depression, a review of the research was conducted which focused on: (1) childhood depression scales and their effectiveness; (2) correlates and antecedents of childhood depression; and (3) environmental supports of invulnerable children. The first issue--related to childhood depression scales--is represented by two research projects. (1) In a study by Poznanski, Cook, Carroll, and Corzo (1983), the Children's Depression Rating Scale (CDRS) was used to test 30 children in a psychiatric hospital. The results found that the CDRS did measure the severity of depression in the children. (2) In a study by Rotundo and Hensley (1985), the Children's Depression Scale (CDS) and the Children's Depression Inventory (CDI) were administered to 84 children in a psychiatric unit. The results endorsed the validity of the CDS to discriminate between different patient groups, and the CDI was also endorsed. The second issue (the correlates and antecedents of childhood depression) is represented by three studies: (1) Sacco and Graves (1984); (2) Billings and Moos (1983); and (3) Kaslow, Rehm, and Stiegel (1984). These studies found common antecedents of childhood depression which included childhoods lacking affection, burdened with resentment, and exhibiting problems in communication. Depressive children were also found to exhibit negative cognitive attributions similar to those of depressive adults. The third issue is treated in an article by Robinson and Fields (1983) in which two case studies of invulnerable children suggest that, in order to avoid the development of a depressive outlook and to foster self-esteem, a supportive environment or at least one significant other is needed to provide support, encouragement, and positive regard. (NB)

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Childhood Depression:

Theories, Antecedents and Supportive Resources

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CG 019193

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Abstract

This paper examines seven studies dealing with childhood depression. The experiments focused on three areas: childhood depression scales and their effectiveness; correlates and antecedents of childhood depression and environmental supports of invulnerable children. The validity of the three depression scales measured (the Children's Depression Rating Scale, the Children's Depression Scale and the Children's Depression Inventory) was endorsed. Common antecedents of childhood depression found included: childhoods lacking affection, burdened with resentment and exhibiting problems in communication. Depressive children were also found to exhibit negative cognitive attributions similar to those of depressive adults. In order to avoid the development of a depressive outlook, a supportive environment is needed, or at least one significant other to provide support, encouragement and positive regard in order to foster self esteem.

Childhood Depression:

Theories, Antecedents and Supportive Resources

Since children tend not to verbally express what they are feeling, the incidence of depression among them is thought to be largely underestimated. Recognizing the importance of early detection and measurement of the intensity of childhood depression, I will first examine studies of two childhood depression scales. These two experiments will be followed by three studies which address the correlates and probable antecedents of childhood depression. Finally, some case studies of invulnerable children may illuminate us to the characteristics and alternative environmental supports which could strengthen children, thus protecting them from impending depressive dysfunction and symptomatology.

Poznanski, Cook, Carroll and Corzo (1983) conducted a study to evaluate how the Children's Depression Rating Scale (CDRS), developed by Poznanski and Cook (derived from the Hamilton Depression Rating Scale), would perform in a psychiatric setting. Previous research had found it to be a reliable instrument for measuring the severity of depression in children when used in a pediatric liaison population. Because of its usefulness in the identification of characteristic behaviors of childhood depression, it can alert the clinician to their presence. Poznanski et al tested 30 children (8-12 years old) at Ypsilanti Regional Psychiatric Hospital including six girls and 24 boys. They also

interviewed their parents and ward personnel. From this information, a global rating given to each subject by two psychiatrists was compared with the SUM from the scale. A SUM score of 15 is a normal baseline score, and under 25 did not indicate depression. Scores between 25 and 35 represent mild depression and over 35, moderate to severe.

The results found that the CDRS does measure the severity of depression in children. All of the low scores (below 25) agreed with the clinicians who had given no rating of depression. Hypoactivity was characteristic of the depressed children. Examination of the clinical records of those assessed as having mild, moderate or severe depression found that only half contained the word 'depression.' Two reasons were suggested for the low reporting of depression in children. The first is the failure to consider the possibility of depression in children under 12. The other points out that the interviewing techniques of child psychiatrists frequently don't include: morbid ideation; suicidal ideation; sleep difficulties and an assessment of the capacity to enjoy life.

Another depression measure, the Children's Depression Scale (CDS) was tested for validity in a study by Rotundo and Hensley in 1985. This is a 66 item self-report scale developed by Lang and Tisher designed for children aged 9 to 16. They tested 84 children within that age bracket at an adolescent psychiatric unit which specialized in affective and anxiety disorders.

The therapist completed three measures for each child: a) rating him on each of six subscales; b) making a judgement whether the patient satisfied the DSM III depression group; and c) making a multiaxial diagnosis on DSM III. The child completed three measures. The first was the CDS whose subscales were summed to give independent total scores for (a) depression (b) positive (c) affective response (d) social problems (e) self-esteem (f) pre-occupation with their own sickness and death (g) guilt and (h) pleasure. They were also given the Children's Depression Inventory as a measure of convergent validity, and the Piers-Harris Children's Self Concept scale. The parents completed the CDS-A (adult form) and the CDI-A.

The results endorsed the validity of the CDS to discriminate adequately between the different groups and the CDI was also endorsed. The scores of the Adult-total D(depression), P(positive) and CDI-A scores differed significantly from each other between the DSM III - depressed and not depressed. None of the adult measures differed significantly between DSM III depressed and not depressed but the child report measures did. The results of the CDI-A confirmed that parents as reporters were the problem.

Sacco and Graves (1984) investigated the antecedents of childhood depression in an effort to apply adult theories of depression to children. They hypothesized that depressed children would perform less well in interpersonal problem-solving situations and rate themselves more negatively on said

performance than non-depressed children. The two theories of depression on which this was based included: a) that the dysfunctional interpersonal responses of the depressed individual play a central role in the development and maintenance of depressive symptoms and b) the cognitive theory. The latter says that depression results from a negative cognitive set causing various emotional, motivational and behavioral disturbances. For this line of reasoning there has been empirical support for adults that they do view their performance on tasks more negatively.

Both theories agree that a lack of social reinforcement and discontinuance of close interpersonal relationships mediate the development and maintenance of depressive symptoms. The experiment involved administering the CDI to 65 caucasian elementary school students. The children were also given the Social Problem Situation Analysis Measure and the vocabulary subtest of the Wechsler Intelligence scale. This was further analysed into four dependent measures (a) interpersonal sensitivity (b) primary expectancies (c) primary means-ends problem solving (d) obstacle expectancies and (e) obstacle means-ends problem solving.

The results yielded significantly lower vocabulary scores for depressed children which might suggest that their deficiency in interpersonal problem-solving performance could be due to

their lower IQs. They also scored significantly lower than non-depressed on social comparison and self satisfaction but did not differ on self evaluation. The inadequate interpersonal skills are specifically in the area of primary means-ends thinking which includes: the tendency to consider alternatives; plan specific steps to be taken; anticipate consequences and anticipate obstacles.

The literature has shown parental psychiatric disturbance to be a risk factor associated with children's vulnerability to psychopathology. When compared with children of non-depressed parents, children of depressed parents exhibited more impairment on indices of depressed mood, withdrawal, fighting and loss of interest in everyday activities. Depressed mothers report childhoods with less affection and more resentment, more problems in communication and more ambivalence toward family members. Research has also found that children are more negatively affected by acutely depressed parents than by those who are chronically depressed, due to the variability of the parent and the quality of the family envirnment. Family environments also differ as to the amount of supportive resources they provide to resist the effects of stress and maintain adjustment.

For these reasons Billings and Moos took a social-environment

perspective in their 1983 comparison study of depressed and non-depressed parents. Specifically they set out to investigate and in some cases confirm the answers to four questions. The first was whether there was more dysfunction among the children of a parent with a unipolar depression than among a matched control group. Another asked if the family environments of the depressed and non-depressed groups differ. They questioned whether the indices of parental functioning, environmental stressors and family social resources would be predictive of the functioning among the children in depressed and non-depressed families and if these effects differ for children of chronic versus nonchronic depressed parents. Finally they examined to what extent parental depression, family stress and lack of social resources increase the risk of children's disturbance.

The study involved 133 depressed parents with children 19 years old or under living at home. They all had a diagnosis of major or minor depression from the Research Diagnostic Criteria (RDC), no indication that the depressive symptoms were of an organic nature and no manic symptoms or significant alcohol abuse in the past six months. A sample of 135 nondepressed control patients were drawn from community members and socio-demographically matched to the patients.

Three questionnaires were administered to each respondent:

The Health and Daily Living Form, which assesses social background factors, parents and children's functioning, family stressors and social resources; The Family Environment Scale (FES) which evaluates the family milieu along a number of dimensions and the Work Environment Scale to assess the stressful aspects of the parent's work setting. This scale includes: a) growth in interpersonal relations; b) personal orientations and c) system maintenance dimensions.

The parents each completed a profile describing the children's functioning in terms of physical health problems; psychological distress; total health problems; behavioral problems and health risks. The parents functioning was also indexed by the occurrence of 18 symptoms and a self confidence rating. The parental stressors and resources were evaluated in six areas : negative life events; personal physical illness; spouse illness; negative physical home environment; family arguments and work stress. An average score from these factors became the global stressors composite. Family resources were also reviewed in terms of the quality of the significant relationship, family support and joint family activities.

The results showed that the children of depressed parents did have substantially more physical and psychological problems including more depression, anxiety and behavioral problems. The children of nonchronic parents had more psychological, physical and total health problems than children of chronic parents. The

family environment of depressed parent families consisted of less cohesiveness and expressiveness and more conflict. There was less emphasis on developing the members independence and moral and religious values and on joint family activities. There was less organization in planning of family activities and less allocating of individual responsibilities.

The higher levels of environmental stressors did increase the problems of the children. Likewise, a supportive and active family environment was associated with fewer symptoms. In fact, even in the control families, high stress and lack of support evidenced greater amounts of child dysfunction. The stressors were equally and significantly predictive of children's functioning in both chronic and non-chronic groups. There was substantial agreement between the ten FES subscale scores of the patients. Thus child disturbance may be broken down into: parental depression; family stressors and mean for global stressors and an unsupportive family environment.

The results of this study point out that not all symptoms reported by children were also reported by parents. Most importantly, children of depressed parents had more depressive symptomatology than control children and this dysfunction extended to aspects of personal adaptation, including emotional, physical and behavioral realms.

A 1984 study by Kaslow, Rehm and Siegel examined symptoms associated with depression in a sample of normal first, fourth

and eighth grade children. Their aim was to assess the relationship between depressive symptomatology and social-cognitive functioning in children and to compare the aspects of cognitive functioning in depressed and nondepressed children and determine the extent to which depression affects cognitive performance differentially. They also investigated developmental differences in performance on affective, social cognitive and cognitive measures in depressed and non-depressed children.

Rehm's self-control model of depression suggests that depressed people show deficits in self-monitoring, self-evaluation, self-attribution and self-reinforcement behavior. Specifically he would expect depressed children to show self control deficits parallel to those in depressed adults including: attending selectively to negative events; setting more stringent criteria for their own performance; evaluating their performance more negatively; exhibiting a more depressive 'attributional style' and punishing themselves more and rewarding themselves less.

Kaslow et al employed 108 children as subjects from the Houston area. During the first session, he administered the Children's Attributional Style Questionnaire (KASTAN), the Children's Depression Inventory(CDI) and the Coopersmith Self Esteem Inventory (CSEI). Three weeks later, a different

experimenter met with each child individually to compile demographic information, self report measures, a family questionnaire, cognitive and social cognitive tasks. The cognitive tasks included: block design; vocabulary; digit span and coding subtests of the WISC-R and trial-making test from the Halstead-Reitan Battery. The social cognitive tasks included the social cognitive inventory and the social competency questionnaire. The teacher also filled out the Achenbach Teacher Rating scale.

The results show that the fourth graders had the most depressive symptomatology but it was not statistically significant. In terms of the family, the more depressed the child, the less positively they reported their environment to be. Of the social-cognitive tests, the KASTAN found depressed children to have made more internal (stable) global attributions for failure and more external (unstable) specific attributions for success than non-depressed children. The CSEI for self esteem showed a strong negative relationship between self esteem and level of depression.

The results of the social cognitive inventory were broken down into four areas. In terms of expectations, depressed children expected to get fewer correct and to take longer to complete it and that they would perform poorly. The standards of the mothers of depressed children incorporated more stringent criteria for failure than did those of non-depressed children.

Depressed girls tended to punish themselves more and depressed children evaluated their work more negatively.

The social competence questionnaire indicated no significant relationship between the child's level of depression and his/her participation in activities, interpersonal relationships or the quality of work he/she does. The teacher rating scale reported that depressed children were more internalizing than non-depressed children.

Therefore the prediction that depressed children would exhibit social-cognitive deficits parallel to those in depressed adults was verified. Specifically, as compared to nondepressed children, depressed children were found to: have lower self esteem; make more depressive attributions and exhibit self control deficits such as negative self evaluation; lower expectations for performance; more stringent criteria for failure and preference for punishment over reward.

In a tangentially related article written in 1983, Robinson and Fields supplied some interesting findings from casework with invulnerable children. Two cases were described in detail. The first was a boy named Ross whose mother spent years in a mental institution. His father was an alcoholic and was out carousing every night. When both parents were home, they argued constantly, frequently leading to aggressive assaults with knives. He eventually

withdrew to his room and wrote adventure stories.

The second case was about Judy who lived with her father, two sisters and a brother in the basement of their home. The mother was a manic-depressive and drug addict who lived upstairs and allowed no-one up with her. When the parents divorced, she lived with her father, stepmother, two step sisters, a step brother, two sisters and a brother. Her brother abused her sexually when she was 12.

Between the ages of six and eight, Judy had gone to four different schools and moved five times. She would frequently find her mother unconscious from an overdose and would call the hospital and make the arrangements to help her mother. She, also withdrew for a few years, but at the age of 12 she came out of her shell, saw life as a challenge and began to excell. Today, Ross is a freelance writer and college professor and Judy, a doctoral student and coordinator of support services for ten school systems. They have stable family lives and long term relationships. They are likeable, intelligent and helpful.

It is important to examine the characteristics which enable Ross and Judy to escape mental illness and remain strong and adaptive in their orientation to life. They had good social skills and felt at ease with others and could make others feel at ease too. They possessed positive feelings of self regard and self confidence and believed that they had the power to influence the

events around them. They felt in control and had the urge to help those in need. Also they both felt a sense of detachment from stressful surroundings. This self distancing became the groundwork for an early sense of independence and an objective understanding of what was going on around him. They developed intellectual and creative skills that were not destroyed by misfortunes at home, in fact the misfortunes seem to motivate them to perform well.

The implications of these findings are of great value in many areas of application. Heredity and the environment most likely interact to produce invulnerability. According to prior research in the area of invulnerability, the child must have at least one good relationship with an adult in order to overcome such distraught life patterns. They need people in their immediate lives who can provide them with a sense of identity, support and encouragement. We need to help them to benefit as much as possible from their strengths. Then by confronting and overcoming their challenges, they gain confidence and competence. Since they develop a sense of autonomy early in life, they can make decisions and handle experiences that confirm their power.

In general, when looking at childhood depression, we need to remember that it exists and include its ideation indicators

in all psychological interviews. It is important to administer either one or more of the valid measures of childhood depression (CDRS, CDS or CDI) to the child and not to expect accurate measurement from testing a parent who reports for the child.

The three studies which examined the elements intrinsic to childhood depression repeatedly pointed clearly to some underlying problems. Looking back one generation, depressed mothers related childhoods lacking affection but burdened by tremendous resentment, problems in communication and ambivalence toward family members (Sacco and Graves, 1984). In concurrance with this picture, Billings and Moos (1983) described the family environments of depressed children as having less cohesiveness and expressiveness and more conflict. If we remember that this mileau represents an entire system of maladaptive emotional patterns, we can see the extension and inflammation of anger turned inward. All of these patterns imprinted on a child at an early age could explain the social cognitive deficiencies and internalizing, negativistic types of attributional thinking. Also both Kaslow et al (1984) and Sacco and Graves (1984) found depressed children to have lower self esteems probably due to the same modeled in the parent. It is not surprizing then to find them lacking in interpersonal skills. Billings and Moos (1983) described the factors succinctly: parental depression; family stressors and unsupportive environment.

In light of these findings, Robinson and Fields (1983) study on invulnerables provides helpful insights. It is interesting that they displayed characteristics exactly opposite to those of depressed children. They key factor seems to be the supportive resource(s) available to the child in an adult significant other who can provide a sense of identity, support and encouragement and instill positive feelings of self regard. The invulnerable children possessed good social skills and felt in control and motivated. The single most revealing finding is that through confronting and overcoming their challenges, they gained extreme confidence and competence. Their autonomy and decisions served to confirm their power. In contrast, the parents of depressed children did not emphasize independence and the resentful, noncommunicative aura of the environment would not reflect or build any positive self regard. The self distancing exemplified by the case studies of invulnerable children may have aided Ross and Judy in refraining from incorporating the cognitive disturbances displayed by their pathological parent, but the deciding factor in their positive, adaptive development was undoubtedly the presence of a supportive, significant adult to strengthen their own self image.

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